CLAIM FORM FOR
MEDICAL, MENTAL HEALTH & FUNERAL EXPENSES
OVERFLOW SHEET

THIS FORM IS TO BE COMPLETED BY THE CLAIMANT

Victim Name: _____

CVR NUMBER: _____ Claimant Name: _____

Your claim investigator is: _____ Phone: _____

Note: The CVR Board is not responsible for your bills. The board is not to be listed as the guarantor on the bill.

STEP 2. OVERFLOW

LIST ALL EXPENSES. Include **itemized** bills from the hospital, doctor, ambulance, dentist, pharmacy, funeral home, cemetery, etc. Do **not** include bills paid in full by your insurance company. Do not write "SEE ATTACHED."

Provider Name	Total Bill	Amount paid by Insurance	Amount paid by Claimant	Amount Owed to Providers

YOU MUST ATTACH A COPY OF THE ITEMIZED BILL **AND** INSURANCE SETTLEMENT FOR EACH EXPENSE CLAIMED.

FOR **MEDICAL TRAVEL**: IDENTIFY MEDICAL PROVIDER, DATES YOU VISITED, MILES ROUND TRIP
(The dates listed below must correspond with the documentation listed above.)

NAME OF MEDICAL PROVIDER	DATES OF VISITS	MILES/ROUND TRIP
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

STEP 3.SIGN HERE _____

DATE _____

SEND THIS FORM AND REQUIRED ATTACHMENTS TO YOUR SHERIFF'S CLAIM INVESTIGATOR.